

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 10/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey (PSR) to the Recertification and State Licensure Survey completed on August 22, 2014. This visit included the PSR to the Investigation of Complaint IN00153896 completed on August 22, 2014.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00156344.</p> <p>Complaint IN00153896 - Corrected.</p> <p>Survey dates: October 8 and 9, 2014</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Survey team: Gloria J. Reisert, MSW/TC Joshua Emily, RN Jennifer Sartell, RN Trudy Lytle, RN Gwen Pumphrey, RN (10/8/14)</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 7 Medicaid: 65 Other: 19 Total: 91</p> <p>Kindred Transitional Care - Rolling Hills was found to be in compliance with 42 CFR Part 483,</p> | | | {F 000} | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 10/09/2014 |
| NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| {F 000} | Continued From page 1 Subpart B and 410 IAC 16.2-3.1 in regard to the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00153896. Quality Review completed on October 10, 2014, by Brenda Meredith, R.N. | {F 000} | | | |